The State of Washington

COMMISSION ON ASIAN PACIFIC AMERICAN AFFAIRS

CAPAA

Improving the lives of Asian Pacific Americans

November 2000 Volume 1, Issue 4

MESSAGE FROM THE DIRECTOR

Dear Friends,

Welcome to CAPAA's fourth newsletter edition. We hope that you find it informative. Please note that beginning in January 2001, we will be publishing quarterly. The new release months are January, April, July and October.

As you know, the health care system is complex and often confusing—as those who are adept at navigating the system can attest. For recent members to our community, the task is daunting, discouraging, and sometimes devastating. Cultural and linguistic barriers are just that—*barriers* to getting meaningful and effective health care.

Documentations about APA community members who are misdiagnosed, mistreated, or dismayed by their health care experience are increasing. Many of our elders and women suffer from severe depression due to cultural and social displacement. However, mainstream mental health services further alienate them by offering services that do not address the causes of their depression, which are rooted in cultural and social disorientation and isolation. These existing health services would be more accessible if they were to focus on the "well-being" of the individual as opposed to the "mental" health—which is often culturally difficult to acknowledge and accept.

If you are interested in the subject of culturally-competent health care, I highly encourage you to read Anne Fadiman's "The Spirit Catches You and You Fall Down," a very readable accounting of how two cultures—Hmong and Western—collide and struggle in the health care system. It offers many insights and lessons.

As always, thank you for taking the time to read our newsletter.

Sincerely,

Miebeth R. Bustillo-Hutchins

South Asian Americans

By Ryan Minato, Research Analyst

South Asia extends southward from the "Roof of the World"—the great mountain ranges of the Hindu Kush, the Karakoram, and the Himalayas—separating the Indian subcontinent from Central Asia and China. South Asians are a diverse lot practicing different religions, including Hinduism, Jainism, Buddhism, Islam, and Sikhism. Like many immigrants, South Asians came to the U.S. in search of better opportunities, faced hardships, and have ongoing challenges today. For some, the U.S. was a secondary or tertiary migration point that began in Africa, the Caribbean, or Britain.

Immigration Waves

Although, the first South Asians came in the 1790s, there were only 523 South Asians in North America in 1898. Between 1899-1913 the first immigration wave brought nearly 7,000 South Asians. These early pioneers were primarily Sikh farmers from the Punjab region who came to California and the Pacific Northwest to work the fields when white nativist hysteria excluded immigration from China, Japan, and Korea. South Asians, however, soon faced significant opposition from organized labor who petitioned to stop immigration from Asia altogether. Under such hostility, many left and by 1940 the number of South Asians decreased significantly, with approximately 2,400 remaining in the U.S.

World War II marked a second immigration wave and public support for South Asians increased as the prospect of India's independence came closer to reality. In 1946, the Luce-Celler bill lifted the ban on South Asian immigration. By 1947, Mahatma Gandhi and the people of South Asia put an end to British colonialism, and many students came to the U.S. to study.

Continued on page 4.

In This Issue

South Asian man: Special Collections Division, University of Washington, UW 15673.

Dear Friends,

Although many South Asian Americans come from English-speaking countries, some do not speak English proficiently. Older first-generation and many of the third-wave working-class immigrants need English-as-a-Second-Language (ESL) and other interpretive programs to access health care services and have fair representation in the justice system. Apart from linguistic-based challenges, South Asians also have other concerns, particularly around domestic violence, discrimination and health care.

Professional South Asians with H-1B temporary work visas are governed by provisions that isolate many of their spouses. Specifically, their spouses—often women—cannot be employed in the U.S. until their husbands get a permanent-resident status. During this period, which could last as long as five to six years, the wife is often confined to being at home and feeling helpless. Such isolation leads to depression; and if domestic violence occurs, the women have few means to seek help for themselves or their children. Indeed, there needs to be a concerted and targeted effort by government agencies and community-based organizations to prevent the incidence of domestic violence and to educate victims about where and how to find assistance.

Also, recent studies and plenty of anecdotal reports show that there is an increase in race-based discrimination and hate crimes against South Asians. Human resources and law-enforcement agencies need to do a better job of preventing, investigating and prosecuting offenses.

Lastly, in the area of health care, the need for ethnicity-desegregated data is very important to identify health disparities between South Asians and other ethnic/racial groups. With such disaggregated information, effective preventive measure can be taken or at the very least enable the community to begin addressing health disparities.

Sincerely,

Habib M. Habib
First Vice-Chair

APA Service Agency Snapshot

Chaya – Domestic Violence Resource for South Asians

By Ryan Minato, Research Analyst

Chaya's mission is to serve South Asian women in time of crisis and need, and to raise awareness about domestic violence issues. This community-based organization works to create a confidential, supportive and culturally-sensitive environment for women seeking support. Chaya provides women with the resources to make informed decisions about appropriate services. Chaya's toll-free helpline allows callers to speak confidentially with a volunteer advocate. Translation and interpretation services are available in several South Asian languages including Bangla, Gujarati, Hindi, Kannada, Malayalam, Marathi, Punjabi, Tamil, Telegu, and Urdu. Chaya also trains service providers and law enforcement agencies about cultural, religious and linguistic issues specific to the South Asian community. In addition, Chaya represents key women's issues at the policy level. To assist with client referrals, Chaya maintains a database of shelters, medical clinics, counseling services, legal and immigration services.

For more information please call (206) 275-2493 or email chaya@oz.net.

24-Hour Hotlines

WA State Domestic Violence Hotline	(800) 562-6025
National Domestic Violence Hotline	(800) 799-7233
Crisis Center Hotline	(800) 244-5767
Domestic Violence Information Line	(206) 205-5555

Confidential Shelters

Seattle	
Catherine Booth House	(206) 324-4943
New Beginnings	(206) 522-9472
East King County	
Eastside Domestic Violence Program	(800) 827-8840
South King County	
Domestic Abuse Women's Network	(425) 656-7867
Thurston County	
Safeplace	(800) 364-1776

Shelters for Women & Family with Children

Chaya	(877) 922-4292
API Women & Family Safety Center	(206) 467-9976
New Beginnings	(206) 783-2848
Refugee Women's Alliance	(206) 721-3846
Eastside Domestic Violence Program	(425) 746-1940
Domestic Abuse Women's Network	(425) 656-8423

South Asian woman: Photo courtesy of Amrik Kamoh.

Policy Brief

Washington State and Health Care

By Joel S. Borja, Legislative Liaison

Structurally the health care system is made up of five overlapping key components: consumers, practitioners, facilities and services, health carriers, payers, and the policies that govern each. There is no cohesive system in place. This article discusses only Washington State's roles as insurance regulator, health profession regulator, and health care purchaser.

Washington State as Insurance Regulator

Federal laws mandate the health care role of the state. For example, the Employee Retirement Income Security Act (ERISA) prohibits states from regulating employers who offer health plans, but allows for the regulation of health care insurers.

In 1889, the state legislature created the Washington State Insurance Commissioner's Office (WSICO) to regulate all insurance business in Washington. Initially, the WSICO registered insurance companies and to oversee compliance and penalty provisions of the State Insurance Code. The WSICO's duties soon expanded to include making sure all authorized insurance companies meet and maintain rigid financial, legal, and other requirements, as well as licensing insurance-related professionals, including agents, brokers, and adjusters.

Today, consumer protection is the most important function of the WSICO. The agency coordinates a wide variety of protective and assistance service through a Consumer Protection Office (CPO). The CPO not only investigates consumer complaints, but also publishes and distributes consumer guides and fact sheets to help Washingtonians decide what kinds of insurance are most beneficial to them.

The most significant trend in Washington today is toward managed care—an integrated system of health insurance, financing, and service delivery. For example, health maintenance organizations (HMOs) either hire or contract with specific groups of practitioners housed in one facility providing a wide spectrum of services. Another type of managed care is the preferred provider organization (PPO), which allows consumers to choose from lists of independent providers and facilities that have contractual agreements with the carrier to work within the rules and pricing guidelines of the PPO.

Washington State as Health Profession Regulator

The Department of Health (DOH) monitors the quality of practitioners in 43 credentialed health professions.

The primary means of identifying and resolving alleged problems by professionals is a complaint and investigation process that results in actions against the licenses of professionals whose practices do not meet state standards.

The current emphasis for resolving concerns about professional practice is on maximum use of technical assistance and other non-disciplinary strategies. These include: 1) standards of practice and guidance in competent practice by professional boards and commissions in concert with the DOH; 2) outreach programs to help providers avoid common problems in practice; and 3) technical assistance to providers with less serious violations to acquire the skills, practices, and internal processes required by current standards.

Washington State as Health Care Purchaser

Washington purchases health care services for persons in every income and age group. These persons include public employees, their dependents and retirees, persons with mental illness, and prisoners. The four largest state administered programs in terms of total expenditure are Medicaid, state employee health benefits, higher education heath care, and community-based services.

Medicaid is a means-tested program with rules mandated by the federal government. It is administered by states and provides medical care for certain populations (members of families with children and pregnant women, and persons who are aged, blind, or disabled) and have the option of covering other populations. Covered services include inpatient hospital care, nursing homes, state facilities for the mentally retarded, home health care, physical services, outpatient hospital care, and prescription drugs. Higher education health care reflects state funding for the operation of state university-based teaching hospitals. Community-based services include alcohol and drug abuse treatment, rehabilitation, mental health, developmental disabilities and vocational rehabilitation services.

The Washington State Health Care Authority (HCA) is responsible for drawing together health plans, health providers, and policy makers to determine the most appropriate ways to purchase and provide health care coverage to Washingtonians. HCA purchases health care services and coverage for the state in the following areas: Public Employees Benefits Board (PEBB); Uniform Medical Plan (UMP); Community Health Services (CHS); Health Policy, Research and Development; and the Basic Health Plan (BHP).

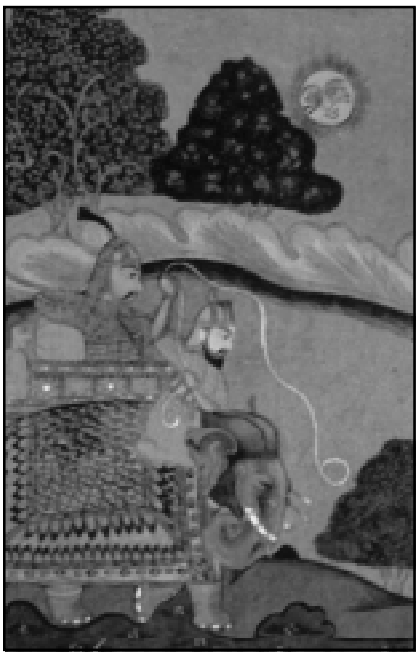
The BHP was established by the Legislature in 1987. It offers subsidized health care coverage for low-income, uninsured people and is designed to provide coverage in high-employment areas of the state.

Sources: Washington State Department of Health, "The Health of Washington State: A Statewide Assessment of Health Status, Health Risks, and Health Systems," 1996; Millbank Memorial Fund, "1997 State Health Expenditure Report"; Washington State Department of Health, "1998 Public Health Improvement Plan."

Photo Courtesy of Miebeth Bustillo-Hutchins, page 3 & 5.

South Asian Americans

Continued from page 1.



The third and largest wave came after the 1965 Immigration Act. Before 1965, approximately 12,000 South Asians lived in the U.S. By 1990, the South Asian American population was 919,626 or a 7,600% increase. Differences in physical features and archaic designation of brown-complexioned South Asians are "Caucasoid" while yellow-toned East Asians are "Mongoloid" contributed to an ambivalence by South Asians to be included in the widening diversity of Asian Americans.

According to the 1990 Census, nearly 90% of South Asians in the U.S. are from India, followed by Pakistan, Bangladesh, Sri Lanka, Nepal, Bhutan, and Maldive. While South Asians make up the sixth largest Asian Pacific American (APA) group in Washington State today, Census 2000 projections expect South Asian Americans (1.2 million) to surpass Korean Americans (1 million) as the fourth largest APA group in the nation.

Exclusionary Laws

Like many Asians, South Asian Americans faced considerable hardships. For example, in 1907, the Japanese and Korean Exclusion League of San Francisco changed its name to the Asian Exclusion League (AEL), to include South Asians. Later that year, the AEL played a key role in attacks on the South Asians in Bellingham and Everett, Washington. In 1923, the Supreme Court ruled that a "white person" is defined by a common man's notion of the term, which resulted in the denaturalization of and the prohibition of citizenship to South Asians.

Current Issues

Most of the South Asians who immigrated to the U.S. between 1965 and 1980s were from the educated elite and middle class of India. By the 1980s, a working class migration began, particularly by farmers from the Punjab and Bengal regions of India and Pakistan where social, political and religious turmoil displaced populations. By the 1990s, it was not unusual to see South Asians working in newsstands, in gas stations, and as cabdrivers. Such educational and economic disparities have implications around labor laws, and anti-discrimination, workforce development and access to health care policies, for example.

Today, among the most difficult and controversial issues facing South Asian Americans are around hate crimes, discrimination, and domestic violence. In 1999, the National Asian Pacific American Legal Consortium reported a dramatic increase in hate crimes directed at South Asian Americans. Also, discrimination is a regular topic in the South Asian American ethnic press, where reports about individual discrimination and the "glass ceiling" are frequent. Another difficult issue to discuss is dom estic violence—a pattern of assault and coercion that takes the form of physical, emotional, verbal, sexual and economic abuse. Since the joint-family system is often the norm in the South Asian community, the abuser(s) may include the in-laws, making it very difficult for victims to find support.

Such issues, however, galvanize the South Asian American community. There are now support organizations for South Asian domestic violence victims. There are also several political South Asian American national federations, the oldest of which is the Association of Asian Indians in America (AAIA), which was formed in the mid-1960s. AAIA along with the National Association of Americans of Asian Indian Descent (NAAAID) successfully fought to establish Asian Indians as a separate category in the 1980 census.

With its increasing numbers, South Asian Americans will undoubtedly become more politically visible.

Biethnic Culture, Religion, and Achievements

Most South Asian American pioneers were members of biethnic communities. In 1930, the men to women ratio for South Asians were 1,572 men to 100 women. This disproportionate sex ratio, combined with California's laws that prohibited marriage across racial lines and landownership by "aliens," made it difficult to establish families. South Asians who decided to settle down in the U.S. sought women whom they could legally marry, the Mexicans and Mexican Americans—who were allowed to own land. Their wives and children became known as "Mexican Hindus," despite the fact that many of the early South Asian men were Sikhs.

In the area of religion, South Asian men who married non-South Asian women encouraged their wives to teach the women's own religious beliefs and practices, while inculcating respect for Sikhism, Hinduism or Islam. This was in keeping with a South Asian expectation that women teach religion and culture to children and in the spirit of Indian tradition of tolerance. Also, not only did their children practice another religion—mainly Catholic—and took on Spanish names, they also spoke Spanish. Mexican-American socialization marked their early years.

Early South Asians and their children soon lost the external signs differentiating Sikh, Muslim, and Hindus. In outward appearance, Sikhs were traditionally distinguished by the beard, long hair and turban required by orthodox Sikhism. American prejudice soon pressured many Sikhs to blend in. Nevertheless, Punjabi men were very political, passionately fighting for U.S. citizenship and freedom for India. They often took their families to political rallies that sought Indian independence from Britain. The children saw themselves and their families as part of the nationalist movement. The right to become U.S. citizens in 1946 and the independence of India and Pakistan in 1947 were highpoints for the first- and second-generation South Asian Americans.

Among other highpoints for the South Asian American community is in 1952, when one of its members, Dalip Singh Saund became the first APA elected to Congress; and in 1998, when Kalpana Chawal became the first Asian woman in space.

Sources: The India Abroad Center for Political Awareness, www.iacfpa.org; Leonard, Karen Isaksen. "The South Asian Americans,"1997; Zia, Helen. "Asian American Dreams," 2000; National Asian Pacific American Legal Consortium, 1998 Audit of Anti-Asian Violence; Indian American Political Advocacy Council, www.iapac.com; Sakhi, "For South Asian Women," www.sakhi.com; Nash, Phil Tajitsu. "AsianWeek, Dalip Singh Saund: An Asian Indian American Pioneer," September 16, 1999.

Access to Culturally Competent Health Care

By Miebeth R. Bustillo-Hutchins, Executive Director

The Asian Pacific Americans (APA)– the fastest growing racial group in the nation and in Washington State– face two distinct, yet interrelated, issues around health care: poor access to health insurance and extremely limited access to culturally competent health care.

U.S. Health Disparity Examples

Vietnamese women's cervical cancer rate, five times that of white women, is the highest among all groups. Native Hawaiians have the highest mortality rates for breast cancer. Asian American women have the highest suicide rates among women ages 15 to 24 and those over age 65. Without health care insurance and culturally competent education and medical programs, many of these women needlessly suffer and / or die due to lack of early diagnosis, early treatment, and appropriate medical care.

Lack of Health Insurance

Health disparities between the white and the APA populations are compounded by poor access to health care services. According to the Henry J. Kaiser Family Foundation's report on *Racial and Ethnic Disparities in Access to Health Insurance and Health Care* issued in April 2000, the lack of health insurance and other health services barriers diminish ethnic minorities' use of preventive services and medical treatments that could reduce morbidity rates.

The same report finds that the higher uninsured rates of ethnic minorities are due in large part to their lower rates of job-based insurance, the main source of coverage for non-elderly Americans. For example, 64% of APAs have job-based insurance, compared to 73% of whites. Overall, 21% of APAs are uninsured, compared to 14% of whites. The result of poor access to health care insurance is poorer health than the white population.

Health care coverage is elusive for many APAs who are self-employed or in situations where there are no health benefits. Policy alternatives could help many, particularly those in low-income brackets. For example, Medicaid and the new Children's Health Insurance Plan (CHIP) could be expanded to include adults in the families of eligible children. Also, the recent Medicaid eligibility limitations for immigrants to seven years need to be reconsidered, or a safety net needs to be in place to help these vulnerable families meet their medical needs when they are no longer eligible for Medicaid. Without such remedies, many individuals will simply get sick, sicker, or die prematurely.

Culturally Competent Health Care

Cultural and linguistic competence allows health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs of diverse patients. For example, an elderly Hmong woman admitted with terminal cancer may pose the following challenges for health care staff and organizations: she and her family do not read, speak or understand English; her cultural norms requires modesty during physical examinations; medical decisions are made by the family as a whole with due respect to the male elders; and her family may have other cultural expectations around the discussions of death.

According to the Office of Minority Health (OHM) in the U.S. Department of Health and Human Services, a culturally and linguistically appropriate response includes interpreter staff; translated written materials and other visual means to communicate complex medical instructions; sensitive discussions about treatment consent and advance directive forms; clinical and support staff who know to ask about and negotiate cultural issues; appropriate food choices; and other measures. These kinds of services have the potential of increasing accurate diagnoses, promoting treatment compliance, and decreasing morbidity rates. Unfortunately, many health care providers do not have a clear guidance on how to prepare for or respond to culturally complex situations. Washington State could provide a framework towards such a guide.

For example, as health profession regulator, Washington State could promote culturally competent services by requiring and arranging for ongoing education and training for administrative and medical staff in culturally and linguistically competent service delivery. As health insurance regulator, it could require health care insurance companies to make interpreters available to limited-English-proficient (LEP) individuals who need help understanding their coverage or accessing providers. There are many other possible standards; and Washington State needs to vigorously consider them in order to meaningfully provide access to culturally competent health care to its increasingly culturally and linguistically diverse population.

Culturally & Linguistically Appropriate Services Standards

To ensure equal access to quality health care by diverse populations, OHM offers the following standards to culturally and linguistically appropriate services (CLAS).

1. Promote the attitudes, knowledge, and skills necessary for administrative and medical staff to work respectfully and effectively in a culturally diverse environment.
2. Have a comprehensive management strategy to implement CLAS.
3. Use formal mechanisms for community and consumer involvement in the design, execution, and evaluation of CLAS.
4. Develop and implement a strategy to recruit, retain and promote qualified, diverse and culturally competent staff.
5. Require and arrange for ongoing education and training for staff in CLAS.
6. Provide all clients with LEP access to bilingual staff or interpretation services.
7. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive free interpreter services.
8. Translate and provide signage and commonly-used educational materials for diverse clients in service areas.
9. Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of medical interpreting.
10. Ensure that the clients' primary spoken language and self-identified race / ethnicity are included in the health care organization's management information system as well as any patient records used by staff.
11. Collect and use demographic, cultural, epidemiological and clinical outcome data for diverse groups, and become informed about the needs and resources of surrounding ethnic communities.
12. Perform organizational self-assessments about cultural and linguistic competence, and integrate measures of access, satisfaction, quality, and outcomes for CLAS into organizational internal audits and performance improvement programs.
13. Develop structures and procedures to address cross-cultural ethical and legal conflicts in health care delivery and complaints by patients and staff.
14. Prepare an annual progress report documenting the organizations' progress with implementing CLAS standards.

A 15th standard or activity is to partner with community-based organizations (CBOs) that already provide health services or outreach to ethnic minority groups. CBOs are often very effective at culturally and linguistically brokering participation among high-risk and hard to reach populations.

Sources: Henry J. Kaiser Family Foundation, "Racial and Ethnic Disparities in Access to Health Insurance and Health Care," April 2000; Office of Minority Health, U.S. Dept. of Health and Human Services, "Assuring Cultural Competence in Health Care," 1999; National Asian Women's Health Organization, www.nawho.org, 2000.

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CAPAA Calendar and Selected Community Events

Events of Interest

Current – Dec. 14, 2000 – "Living Traditions: The Comfort of Home," Short-Term Exhibition, Wing Luke Asian Museum, Seattle. Contact: (206) 623-5124.

Nov. 11 – CAPAA Board Meeting, Oki Foundation, Bellevue, 10 AM-4 PM, free. Contact: (206) 464-5820.

Nov. 14 – The Seventh Annual Executive Development Institute Graduation Dinner, sponsored by the Japanese American Chamber of Commerce, Hyatt Regency Bellevue - Grand Ballroom, 6:30 PM, $75/person. Contact: (206) 320-1010.

Nov. 14 – Blues & Greens Reading by Alan Chong Lau with Suzie Kozawa, Northwest Asian American Theatre, Seattle, 7 PM, free. Contact: (206) 340-1049.

Nov. 14 – Dec. 26 – Asian Pacific Islander Coalition (APIC) Meetings @ ACRS, meets biweekly on Tuesdays with the exception of the 4th Tuesdays of the month to plan for APA Legislative Day, 6-8 PM, free. Contact (206) 695-7582.

Nov. 15 – Seattle Chinatown-International District Preservation & Development Authority 25th Anniversary Reception, Four Seas Restaurant, Seattle, 6-8 PM, free. Contact: (206) 624-8929.

Dec. 3 – Northwest Hawaii 'Ohana Annual Christmas Party, Kitchen/Shelter Peace Arch State Park, Blaine, 1-6 PM. Contact: (360) 715-9212.

Dec. 3 – The Lake Washington Chapter, Japanese American Citizens League Annual Holiday Silent Auction and Installation of Officers Dinner, Best Western Bellevue Inn, 5 PM, $35/dinner. Contact (425) 455-8379.

Dec. 6 – Open House with Photographer Dean Wong, Wing Luke Asian Museum, Seattle, 5-7 PM, free. Contact (206) 623-5124.

Dec. 12 – National PBS Broadcast Premiere of "Conscience and the Constitution," award winning film on WWII and the incarceration of Japanese Americans, KCTS Channel 9, 10 PM. Contact: (206) 722-5971.

Dec. 30 – APA Pre-Celebration of the Chinese New Year, Seattle Center House, 12-6 PM, free. Contact: (206) 684-7200.

Volunteer and Make a Difference

Looking for volunteer or internship opportunities? Please call, (206) 464-5820. You *will* make a difference.

Be Part of the CAPAA Community

If you would like to receive this newsletter or be part of our update list, please contact our office.

The *CAPAA Newsletter* is a publication by the Commission on Asian Pacific American Affairs.

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